

Privatising primary care

The judicial review of the decision to award general practice services in Derby to an American corporation UnitedHealth Europe (UHE) goes to the heart of the corporate takeover of the NHS. Lawyers representing the Secretary of State told the judge that the contract to UHE was no different from replacing a retiring GP, a decision made hundreds of times a year.¹ But this careful choreography has failed to dispel growing anxieties about the aggressive commercial takeover of general practice and other NHS clinical services. There has been little discussion about the risks and costs of opening general practice to the market. When challenged, government replies that general practice has always been run as a business because GPs are independent contractors to the NHS. But there are crucial differences in the policy with serious implications for staff and patients.

First, the 60-year-old arrangements where GPs contract directly with the Secretary of State to provide care has been dissolved. In its place are four new contracting options, each of which is between the government or local health commissioners and healthcare companies. GPs themselves will be under contract to companies or trusts, not the state. The alternative provider medical services (APMS) contract, the fourth route that marks off this reform from earlier revisions, allows commercial companies to hold the provider contract.²

Second, each of the four new contracting routes and associated payment systems combine to end the open-ended commitment to provide care. Instead, primary care services are being broken up into saleable commodities under a process known in the world of privatisation as 'unbundling'. Unbundling limits the general medical service (GMS) contract to a core service that can be topped up with locally negotiated additional elements provided by large corporations. These new entry points and market opportunities for commercial providers are already being exploited for out-of-hours services and immunisation. In addition, under the privately financed investment programme known as LIFT

(Local Improvement Finance Trust), primary care trusts (PCTs) can invite corporations to provide both primary care and clinical care currently provided in hospitals. For example, in Barking and Dagenham, Care UK, a company that doubled its profits last year running care homes and private hospitals, has an APMS contract linked to a LIFT scheme to provide new facilities for elective surgery which will be transferred from local NHS hospitals. Ministers want to shift at least 10% of the hospital budget to primary care, which will be run by independent and private providers.³

The influx of new and large-scale commercial operators will reduce doctors' professional autonomy. Clinical decision making shared with the primary care team will come under the control of commercial managers and shareholders, some of whom will be GP owners like Dr Fradd and Dr Chisolm, of the company Concordia Health, who negotiated the new GMS contract at the British Medical Association.⁴

Although professional autonomy and decision making is being eroded, the government proposes that new contractual arrangements with commercial firms will be free from extensive public interest rules and regulations. 'The contract is intended to be light touch and low bureaucracy,' the government says. 'Achievement' will be demonstrated 'in a single return form to the PCT, to be followed by an annual visit.'⁵ Eventually even the annual visit can be set aside. The principle is 'high trust'⁶ as the government works to redesign the system with the help of major commercial interests, including 'managed care organisations from the US, pharmaceutical companies with expertise in disease management, and independent sector providers in the UK.'⁷

But high trust is not a feature of the regulatory environment in the US where fraud and abuse of tax payer funds abound. UHE, bidding for primary contracts in Derbyshire and elsewhere, is the European subsidiary of America's largest healthcare corporation. UHE's parent, UnitedHealth Group, is a £16 billion corporation based in Minneapolis, US. Its

companies have been involved in multiple fraud cases in the US. In 2004, for example, UnitedHealthcare Insurance settled with the US Attorney for \$9.7 million after being accused of fiddling the books; in 2002 New York State fined UnitedHealthcare \$1.5 million for 'cheating patients out of money'; and cases have continued right up to December last year, when UnitedHealthcare of Georgia was asked to pay more than \$2 million to settle complaints about delayed payments.⁸

In the UK, the new contracts have few quality safeguards to protect patients or safeguards to protect staff. Locally negotiated standards replace national systems and professional standards of care, thereby undoing decades of careful work led by professional bodies, including the RCGP. Locally negotiated quality controls will govern service provision, including provision transferred from hospitals. These regulations will be worked out between the PCT and the contractor subject only to 'a senior clinician (normally the PCT medical or director of public health) ... making a judgement that the framework is comparable to the national requirements'.⁹ Of most concern is the fact that no standards for quality of care are laid down for APMS providers. Their regulation will be through the contract that may never even see the light of day if deemed to be commercially confidential.

An example of the scale of departure from established practice allowed by market deregulation is reflected in this interview with Concordia: '70% of consultations can be led by somebody other than a doctor ... we want to see [staff] develop their own autonomy, acquiring prescribing rights, with doctors becoming consultants in their own organisations. I also see receptionists doing QOF searches, taking bloods, doing BPs, ECGs and new patient checks.'¹⁰ Meanwhile, in the Vale of Aylesbury the PCT has contracted with a private provider for 'an integrated model of care' combining 'dental, medical, nursing and therapy services'.¹¹ The service will be 'nurse led' 'using telephone triage to ensure the appropriate use of clinicians and using

skill mix to aid an effective patient pathway.' None of these new models of care is tested and proved.

But the race to the bottom in quality and standards has only just begun. Now the government plans to allow the private sector to bid for NHS budgets under practice-based commissioning and in July the Department of Health opened primary care commissioning to tenders from large healthcare corporations.¹² As the King's Fund says, the requisite skills for running the new NHS market are to be found not in the UK but 'in the US among health maintenance organisations'.¹³

What might those skills be? The experience of the US is that when corporations hold the budgets they decide what range of services to provide and which patients they will provide for. Their strategy is to minimise financial risk and this means cherry-picking the profitable, and, at the same time, reducing patients' entitlements to health care, instead offering them extra care paid for through patient charges and top up insurance policies. To the UK government, health maintenance organisations (HMOs) are ideal partners in a policy intended to reduce eligibility for NHS care, or, as the government puts it, to 'bear down' on 'differences in the help-seeking behaviour of local populations'.¹⁴

US corporations are well versed in and have opportunity to drive down terms and conditions of staff. For example, Kaiser Permanente, an HMO which has been advising the Department of Health and which proselytises through an NHS 'Kaiser Club', has a strategy of reducing staff numbers and using cheaper and less qualified staff.¹⁵ NHS pensions for all staff who transfer to APMS will not be guaranteed, neither will pay or terms and conditions of services while education and training are likely to disappear rapidly. The government has renegotiated NHS staff and GP and hospital consultant contracts in advance of privatisation to reduce professional influence and trade union bargaining over contract terms, which will be negotiated by corporations on an individual level. Several hospital trusts are now sending confidential patient records to be transcribed in India, the Philippines and South Africa under a new form of outsourcing.¹⁶ Such cost-cutting will

become commonplace in the primary sector too.

US companies are being brought in with the inducement of holding the 80% of the NHS budget that the PCTs hold to commission and to contract for care. Having cherry-picked the profitable treatments, services and patients and dumped the rest, the new corporate forms of HMO will, as in the US, hold the government and the people to ransom. (Public interest issues arising from HMO policies and practices are aired at <http://www.citizen.org/hrg/>).

Whether GP owners like Concordia will behave differently is questionable given that they too will be required to manage the financial risks of accumulating PCT deficits, and rising PFI and LIFT charges for new investment. In the case of LIFT the committee of public accounts has shown that the average annual cost per LIFT GP patient is up to 10 times that of other primary care premises combined. Money intended for direct patient care is now being diverted to bankers and shareholders.¹⁷

There are, however, choices to be made. PCTs do not need to go down the commercialisation route. Other options are available that allow them to retain a geographic focus for planned services. For example, they can avoid alternative providers and service unbundling, only using the three contracting routes other than APMS to keep NHS services out of the commercial sector. They can argue against practice-based commissioning and for population-based planning.

Similarly GPs can take the easy and the greedy route or they can mobilise through the British Medical Association and the colleges, and use all the avenues open to them to force the PCT to protect NHS services for all NHS patients rich and poor, healthy and sick alike. Ultimately, this means demanding a repeal of legislation that establishes health care for corporations and voting to overturn the new GP contract.

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